STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155224	B. WING		10/04/2012		
				ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF I	PROVIDER OR SUPPLIE	R		COLUMBIA ST			
COLUME	BIA HEALTHCARE	CENTER	EVANSVILLE, IN 47710				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0000							
	This visit was for Complaint IN00 Complaint IN00 Federal/State desallegations are of Survey dates: October 3 and 4 Facility number Provider number AIM number: 1 Survey team: Anne Marie Crater Census bed type SNF/NF: 158 Total: 158 Census payor type Medicare: 27 Medicaid: 115 Other: 16 Total: 158 Sample: 4 These deficience	or the Investigation of 0117509. 0117509 Substantiated, efficiencies related to the cited at F309 and F514. 1, 2012 1: 000129 2r: 155224 00266780 Anys RN e:	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after Octo 24, 2012.	ot s n of hat		
	16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI 10/04	E SURVEY PLETED 4/2012
	PROVIDER OR SUPPLIER		621 W	ADDRESS, CITY, STATE, ZIP COLUMBIA ST	CODE	
	BIA HEALTHCARE			VILLE, IN 47710		_
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
IAU	Quality review com Cathy Emswiller RI	pleted 10/5/12	IAG			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1IAG11

Facility ID: 000129

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155224	B. WING 10/04/2012			
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8		COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		SVILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0309 SS=D	HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial well the comprehensive care.	ust receive and the facility necessary care and or maintain the highest	F0309	F309 Each resident must	10/24/2012	
	facility failed to resident in distrete by a CNA, for 1 for quality of car Resident A Findings included The closed clinic was reviewed on The record indice "Full Code." Progress Notes in notations: 9/30/12 at 10:10 [resident] room [and] alert et ans appropriately. Resounds in bronch	ensure a nurse assessed a ess when asked to do so of 3 residents reviewed re, in a sample of 3.	F0309	receive and the facility must receive and the facility must provide the necessary care ar services to attain or maintain thighest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment a plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident no longer in facilit How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents have the potent to be affected by the alleged deficient practice. Nurse Managers will round daily to ensure any changes in condition are assessed and documented appropriately Audit has been completed the ensure any resident with	nd the the nd e ed y. al en? ntial	
	get oxygen et ca res. room et state	Il MD. CNA came out of ed res. had stopped started et 911 called.		suspected change in condition has been assessed and findin reported to physician and fam Care plan and C.N.A. assignn	gs ily.	

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Event ID: 1IAG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155224	B. WIN			10/04/2012	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R					
COLLIME	BIA HEALTHCARE	CENTED	621 W COLUMBIA ST EVANSVILLE, IN 47710				
	DIA FILALITIOANE	CLIVILIX		LVAING	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	D.	ATE
					sheets updated to reflect any		
	On 10/3/12 at 4:	15 P.M., during interview			changes.		
	with CNA # 1, s	he indicated she was			What measures will be put in	to	
	· ·	evening of 9/30/12. CNA			place or what systemic		
	_	sident A "didn't seem like			changes you will make to ensure that the deficient		
					practice does not recur?		
		She indicated, "CNA # 2			·Licensed nursing staff has		
	_	's] aide." CNA # 1			been educated on assessmen	t I	
	indicated CNA #	# 2 asked RN # 1 and			and documentation policy.		
	another nurse, w	hose name she was			DNS/SDC trained all licensed		
	unsure of, to con	ne down and look at			nursing staff by October 24,20	12.	
	Resident A, because he was having trouble breathing. CNA # 1 indicated RN				·Licensed Nursing staff will		
					be instructed to assess any		
	_				resident identified by any staff		
		2 that she "was going			member to be in distress.	14	
		indicated LPN # 2 then			·DNS/Designee/UM will cond rounds daily on all shifts to	auct	
	assessed the resi	dent.			validate that regular scheduled	.	
					assessments are completed a		
	On 10/3/12 at 4:	25 P.M., during interview			assessments are done for any		
	with LPN # 2. sł	ne indicated she had taken			suspected change in condition		
		the evening of 9/30/12,			How the corrective action(s)		
		me back to the unit, CNA			will be monitored to ensure t	he	
		,			deficient practice will not rec	ur,	
		that Resident A " wasn't			i.e., what quality assurance		
		N # 2 indicated she			program will be put into plac		
	assessed the resi	dent at that time, and he			·Staff has been educated on		
	was "real gurgly	"." LPN # 2 indicated she			assessment and documentation	on	
		m to call the physician			policy.		
	and obtain oxyge				·The DNS/designee will complete CQI tool 5X weekly	× 4	
	colum onyg				weeks, weekly X 4, and quarte		
	On 10/2/12 -4 4:	45 D.M. duning inter-			thereafter. For a minimum of 6	-	
		45 P.M., during interview			month		
	· ·	e indicated she was			·All audit tools will be brough	ıt	
	working the ever	ning of 9/30/12. RN # 1			before the CQI committee		
	indicated she had	dn't been feeling well, and			monthly		
	was supposed to	go home early, when a			·Any non-compliant issues n		
		ner "so and so is sick and I			be addressed with re-educatio		
		ck him." RN # 1 indicated			and/or disciplinary action up to		
	need you to chec	KIIIII. KIN# I IIIQICATEQ			and including termination.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155224		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 10/04/2012		
		100224	B. WIN		PDDDGG GWYL GW	10/04/	ZU 1Z
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	Compliance date: October 24	1	DATE
	she informed the CNA to "please ask				2012		
		at the desk" because she					
		ish up her work. RN # 1					
		s unaware if the CNA					
	1	ne else. RN # 1 indicated					
		g the narcotics with RN #					
		NA came up and said the					
	_	oped breathing, and then					
	RN # 1 and RN i	# 2 ran to the room.					
	On 10/3/12 at 5:25 P.M., during interview with CNA # 2, she indicated that on						
	9/30/12, she had	noticed Resident A					
	"wasn't himself,	" and was "panting, eyes					
	were dancing, he	e wouldn't eat supper."					
	CNA # 2 indicat	ed at approximately 9:30					
	P.M. or 9:45 P.N	1., her nurse, LPN # 2,					
	was taking a bre	ak, and she was very					
	worried about Ro	esident A. CNA # 2					
	indicated she we	nt up to the nurses desk,					
	and asked RN #	1 if she would "please					
	come here and h	elp me - I'm worried					
	about [Resident	A's] breathing." CNA # 2					
	indicated RN # 1	told her, "I'm getting					
	ready to get off -	go ask someone else."					
	CNA # 2 indicat	ed she was so surprised					
	by RN # 1's com	ment that she just walked					
	back to Resident	: A's room. CNA # 2					
	indicated at abou	it that time LPN # 2 was					
	coming back fro	m break, so she asked her					
		ne resident. LPN # 2					
	immediately wer	nt into the resident's					
	room, and assess						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
11112 12111	or confidence.	155224		LDING		10/04/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		40 P.M., during interview		TAG	DLI ICILITO I)		DATE
		he indicated she was					
		evening of 9/30/12. CNA					
	•	NA # 2 came to me and					
	•	ok at [Resident A]." CNA					
		sident A's "skin was a					
	funny color," and	d he was not breathing					
	right. CNA # 3 is	ndicated CNA # 2 said					
	"a nurse told me	to find someone else" to					
	check on the resi	dent.					
	On 10/4/12 at 9:	10 A M. during					
		NA # 5, she indicated					
		the evening of 9/30/12.					
	_	ed Resident A's nurse					
		and there were 2 nurses					
	· ·	k. CNA # 5 indicated					
	CNA # 2 asked t						
	Resident A, "but	they didn't want to check					
	on him."						
	On 10/4/12 -4 10	1000 A.M. Almire					
		0:00 A.M., during ne Administrator, she					
	indicated she did						
		1 not assessing Resident					
		nd RN # 1 had received a					
	written warning						
	This federal tag	relates to Complaint					
	IN00117509.	-					
	3.1-37(a)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 10/04	LETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST	DE	
COLUME	BIA HEALTHCARE	CENTER		VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155224	B. WIN			10/04/	2012
NAME OF B	DOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			621 W (COLUMBIA ST		
	BIA HEALTHCARE (CENTER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514 SS=D	483.75(I)(1) RES						
55=D		PLETE/ACCURATE/ACCE					
	SSIBLE	1 LETE/NOODIV (TE/NOOL					
		maintain clinical records on					
		accordance with accepted					
		dards and practices that					
		curately documented; e; and systematically					
	organized.	e, and systematically					
	organizoa.						
	The clinical recor	d must contain sufficient					
information to identify the resident; a record of the resident's assessments; the plan of							
		s provided; the results of a screening conducted by					
	the State; and pro	•					
		ew and record review, the	F05	14	F514 The facility must maintain	n I	10/24/2012
		ensure documentation			clinical records on each reside		
	_	regard to the assessment			in accordance with accepted		
	_	mplaints of abdominal			professional standards and practices that are complete;		
		esidents assessed for			accurately documented; readily	v	
	•	in a sample of 4. Resident			accessible; and systematically		
	A	F			organized. The clinical record		
					must contain sufficient		
	Findings include				information to identify the resident; a record of the		
	- manigo morado	•			resident's assessments; the pl	an	
	1. On 10/4/12 at	9:10 A.M., during			of care and services provided;	the	
		NA #5, she indicated she			results of any preadmission	esta	
		he facility on 9/29 and			screening conducted by the St It is the policy of the facility that		
	_	5 indicated Resident A			services provided What	``	
		of stomach pains, and			corrective action(s) will be		
	-	to the hospital on 9/29			accomplished for those		
	•	it." CNA # 5 indicated			residents found to have been	1	
	_				affected by the deficient		
		ident complain, and			practice?		
		4 in cleaning up the			Resident A no longer at the facility How will you identify		
	resident when he	e vomited. CNA # 5			other residents having the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00			COMPLETED	
		155224				10/04/2	2012	
			B. WIN		ADDRESS STATE TIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE			
00111145		OFNITED			COLUMBIA ST			
COLUME	BIA HEALTHCARE	CENTER		EVANS	SVILLE, IN 47710			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	indicated RN # 2	2 was aware of the			potential to be affected by th	e		
resident's complaints.				same deficient practice and				
	resident's compi	uiii.			what corrective action will be	e		
	0: 10/4/12 -4 1.	15 D.M. A. dina linkan in			taken?			
		15 P.M., during interview			·All residents that reside with			
		he indicated she was			the facility have the potential t			
	working on 9/29	O. CNA # 4 indicated			affected by the alleged deficie	nt		
	Resident A "was	s bloated, hurting, and			practice.			
	was wanting to s	go to the hospital." CNA			· All nurses/have been			
		e informed RN # 2. CNA			in-serviced on documentation requirements and importance	of		
					documentation of assessment			
# 4 indicated the resident vomited "dark				DNS/SDC will inservice all	.5.			
	brown liquid."				licensed nursing staff by Octo	ber		
					24, 2012.			
	On 10/4/12 at 9:	30 A.M., during			·Nurse managers have			
	interview with R	2N # 2, she indicated she			received training to audit nurs	e		
	was working at t	the facility on 9/29/12.			documentation to ensure that			
		e was informed early			documentation of assessment	s		
		•			was completed. DNS/SDC to			
		probably around 6 or 7			train nurse managers by Octo			
	· ·	dent A's "belly hurt." RN			24, 2012. What measures will			
	# 2 indicated she	e assessed the resident,			put into place or what system	nic		
	and his abdomer	n was large, "but it was			changes you will make to ensure that the deficient			
	always large." R	N # 2 indicated the			practice does not recur? How	.,		
		bing his lower abdomen.			the corrective action(s) will be			
		d she heard bowel sounds			monitored to ensure the	~		
		ed to the resident. RN # 2			deficient practice will not rec	ur.		
					i.e., what quality assurance	····,		
		ident did not vomit, and			program will be put into place	e?		
	she did not feel	the physician needed to be			·Licensed nursing staff has			
	notified.				been educated on assessmer	ıt		
					and documentation policy.			
	Documentation regarding the resident's				DNS/SDC trained all licensed			
				nursing staff by October 24,20				
	complaints of abdominal pain, or the nursing assessment, was not observed in				· Nursing staff will be instruction			
		·			to assess any resident identifi	ed		
	the clinical reco	rd.			by any staff member to be in			
					distress and document finding DNS/Designee/UM will con			
	2. On 10/4/12 at	2:15 P.M., the Director			DIAG/Designee/OW will con	uuul		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S OO COMPLE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155224	A. BUILDI	NG	00	10/04/	
		133224	B. WING	TEN FEET A	DDDEGG GITTY GT ATT GID GODE	10/04/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	of Nursing prov policy on "Docu nursing," revise included: "Purp document in an information rela medical record. nursing progres specific condition pain symptoms.	ided the current facility amentation guidelines for d 6/2012. The policy ose: To accurately organized manner all ated to the resident in the a.Daily charting in the s notes on resident ons including vital signs,			rounds daily on all shifts to validate that regular scheduled assessments are completed a assessments are done for any suspected change in condition and documentation is complet for assessments The DNS /designee will complete documentation CQI is 5X weekly X 4 weeks, weekly 4, and quarterly thereafter. For minimum of 6 months All audit tools will be brought before the CQI committee monthly Any non-compliant issues in the addressed with re-education and/or disciplinary action up to and including termination. Compliance date: October 24 2012	e tool X r a t e	

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PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY IPLETED 04/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION'S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
		,						

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